Chapter 2:
Cost of Health Care

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The cost of health care has long been a leading domestic issue for the American people. In 2007, $2.2 trillion was spent on health care in the U.S. - an average of $7,421 per person. The federal government estimates that health care costs more than tripled from 1990 to 2007.[1]

Health care spending constitutes 16.2 percent of the gross domestic product (GDP)[2] and is projected to rise to 25 percent of GDP in 2025 and 49 percent in 2082.[3] (See chart, "National Health Spending as a Percentage of GDP.") Medicare and Medicaid together, which made up 5.5 percent of GDP in 2007,[4] are expected to equal 19 percent of GDP in 2082, making health spending a major force behind rising federal spending in the coming decades (and an obvious target for budget cutters).[5]

For every dollar spent on health care, 31 cents goes to hospitals, another 31 cents to professional services (including physicians and dentists), 10 cents to prescription drugs bought at retail, and 6 percent to nursing home care.[6] (See chart, "Where the Health Care Dollar Goes.")

Health spending in the U.S. stands above that in other developed countries, both per capita and as a percent of GDP. (In GDP terms, U.S. spending is at least 40 percent higher than in Germany, Belgium, Japan, the Netherlands, Canada, Italy, Sweden or the United Kingdom.)[7]

About a third of total payments in 2007 (34.6 percent) came from private health insurance. Medicare paid for 19.2 percent of care, Medicaid (both federal and state) paid for 14.7 percent and consumers paid for 12 percent of care out-of-pocket.[8] (See chart, "Where the Health Care Dollar Comes From.")

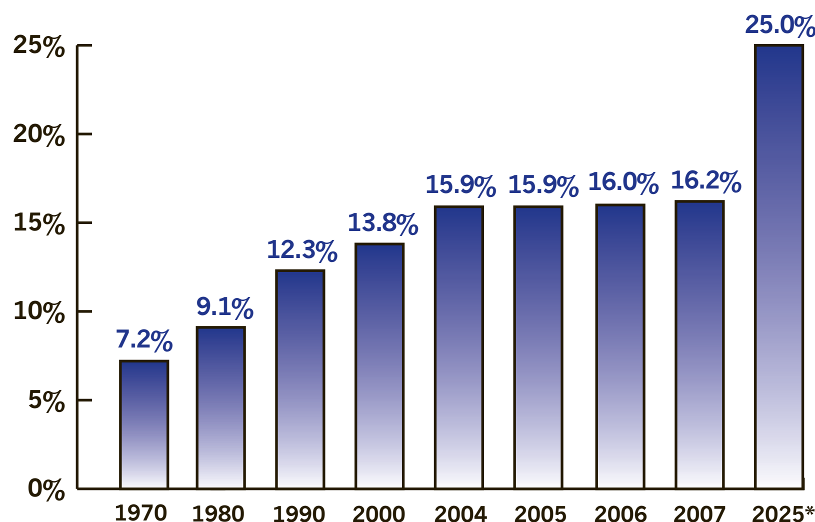
What is driving the rise in costs? Primarily, medical technologies and services, most analysts agree - not only new technologies, but also new uses for existing technologies. This has been true for at least 50 years, and is true for all developed nations. Other drivers include the spread of health insurance (which isolates consumers somewhat from the true costs of care), increased personal incomes (which helps drive demand), worsening health status (particularly obesity) and low productivity gains in the health care sector.[9,10]

The elderly account for a

For story ideas on the cost of health care, see page 19. A list of experts and websites begins on page 20.

FAST FACTS

- The United States spent $2.2 trillion on health care in 2007, or $7,421 per person. This amounted to 16.2 percent of the nation's gross domestic product (GDP).[a]
- Health care costs more than tripled from 1990 to 2007,[b] and are projected to rise to 25 percent of GDP in 2025 and 49 percent in 2082.[c]
- The average cost of an employer-based family insurance policy in 2008 was $12,680, close to the annual earnings of a full-time minimum wage job.[d]
- Premiums for employer-sponsored family health coverage more than doubled from 2000 to 2008.[e]
- The tax exemption for employer health premium contributions is the nation's largest tax expenditure,[f] totaling $246.1 billion in federal revenue passed up in 2007.[g] This is more than half the amount that the federal government paid for Medicare that year.[h]



Source: Hartman, Micah; Martin, Anne; McDonnell, Patricia et al. (2009). "National Health Spending In 2007: Slower Drug Spending Contributes To Lowest Rate Of Overall Growth Since 1998." Health Affairs, Jan./Feb., p. 247. (www.healthaffairs.org). See also: Orszag, Peter; Congressional Budget Office (2008). "Growth in Health Care Costs." Testimony before the Senate Budget Committee, Jan. 31, p. 1. (www.cbo.gov/doc.cfm?index=8948).

disproportionate amount of health care spending, with nearly half of lifetime expenditures per capita occurring after age 64.[11] But population aging plays only a minor role in explaining health cost increases over time.[12] (See chart, "Sources of Growth in Projected Federal Spending on Medicare and Medicaid.") Most analysts also conclude that defensive medicine induced by fears of malpractice suits does not contribute to much of the growth.[13]

CONSEQUENCES OF RISING COSTS

The rise in health care costs has affected the health and financial well-being of individuals and families, and the fiscal futures of employers and governments.

Especially during the ongoing recession, health care costs have been a source of stress for private sector employers, who provided $532 billion in health benefits in 2007.[14] Some major U.S. automakers, for example, note that they spend more on health care than on steel for their cars.[15,16] The average cost of an employer-based family insurance policy in 2007 was $12,680,[17] close to the annual earnings of a full-time minimum wage job. Premiums for employer-sponsored family health coverage more than doubled from 2000 to 2008.[18]

Likewise, employees and self-employed individuals have been feeling the pinch. A study by the Center for Studying Health System Change found that 57 million Americans were in families having trouble paying medical bills in 2007.[19] Almost a quarter of respondents in a 2008 poll by the Kaiser Family Foundation said they had experienced a serious problem paying for health care or health insurance as a result of the recession.[20]

The amounts that workers pay for their coverage have far outpaced inflation. In 1999, workers paid an average of $129 monthly for family coverage and $27 for single coverage. By 2008, those amounts had grown to $280 (up 117 percent) and $60 (a 122 percent rise).[21] Inflation over that period amounted to 28 percent.[22]

Employers compensate for rising health care costs in part by keeping a lid on wages. One study estimates that an employer's expenses for health benefits are offset by a 9 percent reduction in wages.[23]

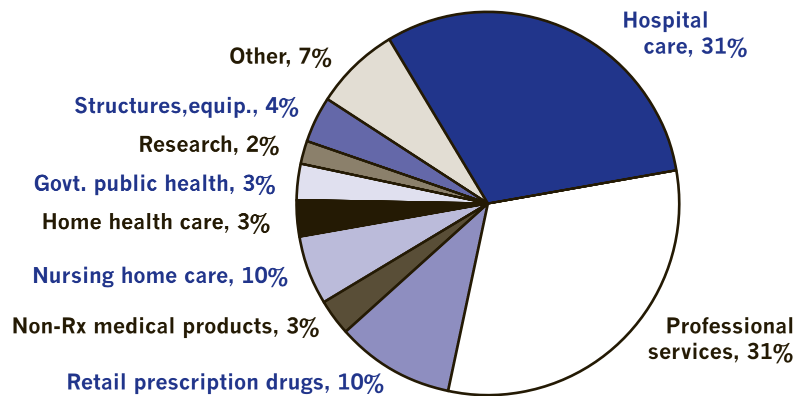
In late 2008, the Congressional Budget Office issued a report laying out how it will go about estimating the impact of various proposals to reform health care. In describing why this task was so important, CBO painted a dire picture of what might happen if health care costs cannot be controlled. According to CBO, "rising costs of health care and health insurance pose a serious threat to the future fiscal condition of the United States….Without changes in policy, a substantial and growing number of nonelderly people…are likely to be without health insurance."[24] (For a detailed CBO analysis of some ways to restrain costs, see the report, "Budget Options: Volume 1 - Health Care," at www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf.)

LIKELY POLICY DEBATES

As health care costs continue to place pressure on both public and private insurers, debates about health care reform and entitlement reform will surely involve ways to constrain costs.

The task won't be easy. Health economists speaking at an Alliance for Health Reform - Robert Wood Johnson Foundation briefing in 2008 noted how hard it is to control demand for health services, which some believed to be the only way to constrain costs.[25] Some of the methods tried or proposed include:

Where the Health Care Dollar Goes



Source: Hartman, Micah; Martin, Anne; McDonnell, Patricia et al. (2009). "National Health Spending in 2007: Slower Drug Spending Contributes to Lowest Rate of Overall Growth Since 1998." Health Affairs, Jan/Feb., p. 247. (www.healthaffairs.org).

INCREASED COST-SHARING

Cost-sharing involves out-of-pocket spending by consumers for insurance deductibles, coinsurance, copayments, and premium contributions (see glossary for definitions). As health care costs have risen, employers and public programs have shifted costs to consumers (see text box on rising costs and access to care).

By increasing the amount of out-of-pocket contributions from patients, cost-sharing schemes can increase patient cost-awareness in health care decision-making, providing an incentive to pursue less-costly treatments. One example of this effect is tiered copayments for prescriptions, which give consumers an economic incentive to select generic medications rather than brand name drugs. This incentive system helped increase the dispensing rate of generics from 56 percent of prescriptions in 2005 to 63 percent in 2006.[26]

CONSUMER-DIRECTED HEALTH PLANS

Making patients more aware of costs is also the reasoning behind consumer-directed health plans, which link a high- deductible health plan with tax-sheltered health reimbursement accounts (HRAs) or health savings accounts (HSAs). (See glossary for definitions.) Patients make out-of-pocket health care payments from their HRA or HSA until they have reached their yearly deductible amount, at which point their health plan starts picking up expenses.

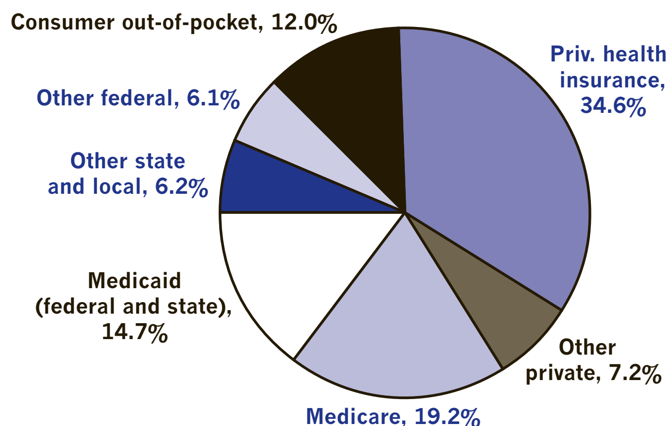
Enrollment in such plans is growing slowly. A report by the Employee Benefit Research Institute found that in 2008, 3 percent of privately insured people aged 21 - 64 were enrolled in an HSA or HRA linked to a high-deductible health plan. This compared with 2 percent in 2007.[27]

CHANGES IN PROVIDER REIMBURSEMENT

Payments to physicians and hospitals made up 52 percent of all health care spending in 2007.[28] Thus, many methods have been tried to reduce payments to providers as a way of reining in health care costs.

Medicare is moving toward pay-for-performance reimbursement, whereby a specified percentage of a hospital's payment would be based on performance measures, ranging from giving smoking cessation advice to perioperative antibiotic administration.[29]

Payers can also simply decrease the amounts they pay providers. Medicare's Sustainable Growth Rate (SGR) policy is supposed to do this, aiming to keep total spending for physician services in Medicare Part B under a defined target figure.[30] (See the Medicare chapter for more information about the SGR.) The Balanced Budget Act of 1997 significantly cut Medicare reimbursements to providers. Similarly, from 2003 to 2005, several states reduced or froze Medicaid reimbursement rates in response to budget shortfalls.[31] In the private sector, insurance companies try to negotiate lower rates.



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However, each of these policies can have unintended consequences. Providers may (and do) drop patients from lower-paying insurance plans, or refuse to accept them in the first place.[32] Congress has often overridden the cuts mandated by the Sustainable Growth Rate.[33] And there is some (albeit conflicting) evidence to suggest that cutbacks to hospitals may decrease the quantity of services provided and adversely affect patient outcomes,[34,35,36] calling into question the sustainability of further cuts.

HEALTH INFORMATION TECHNOLOGY

Substantial financial support for health information technology (IT) expansion occurred early in the 111th Congress, buoyed by its bipartisan backing and the enthusiasm shown by the Obama Administration. Electronic medical records can result in improved coordination of care among health care providers, reduce medical errors, and enable easier, standardized measurement of health care cost and quality. Moreover, improved clinical decision support for providers could decrease variability in the use of health care services.

But whether health IT can save substantial sums is at yet unanswered. Peter Orszag, director of the Office of Management and Budget, has concluded that health information technology alone is not sufficient as a cost saver without other simultaneous changes in the health care system.[37]

CHRONIC DISEASE MANAGEMENT

From 1987 to 2002, two-thirds of the growth in Medicare spending was for 10 chronic medical conditions, with 12 percent for heart disease alone.[38] A greater prevalence of chronic disease in the U.S. compared to its European counterparts, and higher rates of medication treatment of chronic diseases, are also believed to underlie some of the health care cost differences between the U.S. and its European counterparts.[39]

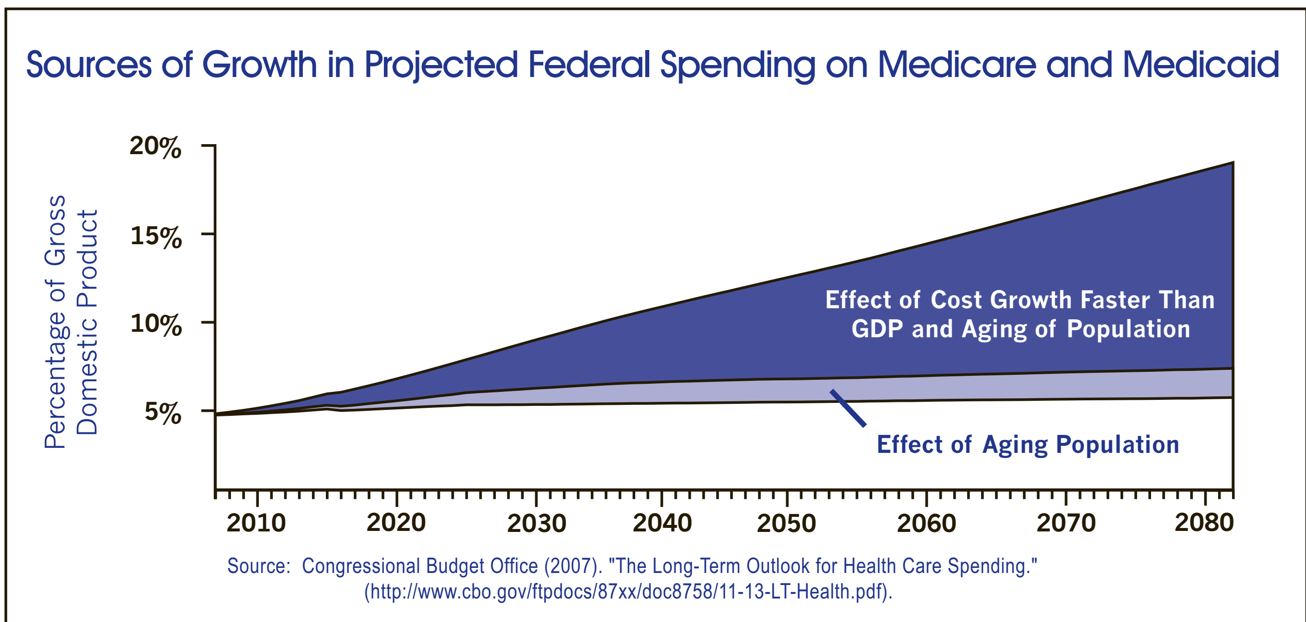
Therefore, the prevention of chronic disease, and the improved, coordinated management of chronic disease once it develops, is critical to providing more cost-efficient, high quality care.

But disease-management has mixed results as a cost-containment tool. Eight pilot programs conducted by Medicare did not reduce costs, largely because the sickest and most vulnerable (and thus most costly) patients were less likely to agree to participate in disease-management efforts.[40] Other studies have shown that efforts at preventing and dealing with chronic diseases typically add to health care spending, rather than reducing it. A review of 1,500 interventions for prevention and treatment found that about 20 percent did lower costs. The rest added more costs than they saved.[41]

PHARMACEUTICALS

Prescription drug spending increased 4.9 percent in 2007, according to the Centers for Medicare and Medicaid Services. This was a deceleration from the 8.6 percent growth in 2006.[42] (Some research suggests the rate of growth in 2007 may have slowed even more.)[43] This deceleration is occurring as brand name drugs face increased competition from generics and insurers aggressively used tiered formularies. The federal government estimates prescription drugs spending will grow by an average of 6.5 percent a year from 2008 - 2018.[44]

The United States is known to have higher prices for medications than its European counterparts; indeed for several European countries, the price of 150 of the most popular drugs was 60 percent or less of the price in the U.S.[45] Other analysts suggest that these differences may be overstated.[46] Patents for pharmaceutical companies enable higher prices for protected brand names.



Some suggest the following ways that government might lower costs: using the large market share of the elderly population to negotiate lower prices with pharmaceutical companies, allowing importation of medications from other countries where they are cheaper, or revising patent laws to allow for generics to be brought to the market sooner.

One concern with all of these methods is that pharmaceutical profits provide the needed capital and incentive for research and development. In 2002, 82 percent of the investment by global pharmaceutical companies was spent in the United States, and pharmaceutical companies employ over 223,000 American workers.[47] Safety questions also would arise with imported drugs.

OTHER METHODS

Many other cost-containment ideas have been implemented or proposed. These include reducing public program fraud and abuse, capping amounts paid out in malpractice judgments, boosting efforts to prevent disease, and sending Americans overseas for major surgery in less expensive countries. None to date has emerged as having a major impact on overall costs.[48]

TIPS FOR REPORTERS

- Cost containment will be a key consideration in upcoming health care policy debates.
- Consideration of health care quality and outcomes goes hand-in-hand with issues of health care costs.
- Consider all of the various players in looking at health care costs. This includes health care providers, patients, payers, government, employers (large and small), employees, and health insurance plans. Each will have different interests and will be affected differently by policy changes.
- The financial effects of health care policy should be considered in both the short and long term; a short term investment may lead to long-term cost savings.
- The way health care is financed can affect the way health care is provided. For example, the tax exclusion of employer-provided benefits creates an incentive for employers to provide health benefits to their employees. Changing that exclusion could create a disincentive.

STORY IDEAS

- Contact local employers, both small and large, and find out how rising health care costs have affected their business practices. This can include pricing of products, business investments, other employee benefits, and contract negotiations.
- Find out what kinds of changes local employers

have made to their health plans in terms of increased cost-sharing (copayments, deductibles), alternative plan structures such as Health Savings Accounts, or dropping coverage. What do they consider to be the pros and cons of each option? How have employees reacted to such changes?

- Interview providers about whether the level of cost-consciousness in health care has changed in recent years, among providers and among patients. What kinds of efforts have been made by providers to incorporate cost in management decisions?

- Interview local hospital officials to find out what utilization management or education programs have been or are being implemented to try to make health care provision more cost-efficient. This could include an examination of physician practices compared to their peers, programs to prevent medical errors and complications, and health prevention.

- Interview employers as to what employee wellness, educational, or health utilization programs they have implemented to try to rein in health care costs. Have they found these programs to make a difference? How have employees responded to them?

- Contact local government officials and find out what the challenges they face in covering Medicaid patients and administering public health programs. What measures have been taken to manage the costs? How might the recession affect funding for public health programs?

- Contact administrators at local health insurance plans to find out which areas have generated high costs and what efforts have been made to streamline care in those areas. Examples could include efforts to move away from care provided in the emergency room setting toward primary care office visits; wellness and prevention programs; and incentive structures for providers.

- Conduct a round-table discussion or focus group with members of the community to discuss rising health care costs. What do they think are the causes? Would higher co-payments and deductibles make them more cost conscious in their decisions? Would it lead them to not access care? What are areas to target?

The Effect of Rising Costs on Access to Care

As health care costs rise, Americans have found it increasingly difficult to keep up. Employers have scaled back coverage and increased cost-sharing. The median deductible required by large employers for single, or individual, coverage in preferred provider (PPO) health plans jumped to $1,000 in 2008, up from $500 the previous year, according the Mercer consulting firm.[1] PPOs are the most popular type of health plan.

The number of non-elderly Americans living in families spending more than 10 percent of their income on health care premiums and cost sharing rose from 15.9 percent to 17.7 percent between 2001 and 2004.[2]

Even more concerning is the fact that employers - mostly small businesses - are dropping coverage. From 2000 to 2007, the number of non-elderly Americans covered by employer-based health insurance fell from 68.3 percent to 62.9 percent.[3] As a result, nearly half of the increase in the uninsured among children has occurred in middle-income families.[4] It has been well-documented that the uninsured are less likely to obtain needed, high quality care. [5,6]

[1] Mercer (2008). "So what happens in next year's tough business environment?" News release, Nov. 19. (www.mercer.com/print.htm?indContentType=100&idContent=1328445&indBodyType=D&reference=).

[2] Banthin, Jessica; Cunningham, Peter; Bernard, Didem (2008). "Financial burden of health care, 2001-2004," Health Affairs; 27(1): 189-190. (www.healthaffairs.org).

[3] U.S. Census Bureau. "Table HIA-6. Health Insurance Coverage Status and Type of Coverage by State--Persons Under 65: 1999 to 2007." (www.census.gov/hhes/www/hlthins/historic/hihistt6.xls).

[4] Holahan, John; Cook, Allison (2007). What Happened to the Insurance Coverage of Children and Adults in 2006? Menlo Park, CA: Kaiser Family Foundation. (http://www.kff.org/uninsured/upload/7694.pdf).

[5] Institute of Medicine (2003). "Hidden Costs, Value Lost: Uninsurance in America." Washington, DC: National Academies Press, June. (http://www.iom.edu/Object.File/Master/12/327/Uninsured5FINAL.pdf).

[6] Dorn, Stan (2008). "Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality." (http://www.urban.org/UploadedPDF/411588_uninsured_dying.pdf).

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Financing Health Care Reform

As policymakers look to address our nation's health care problems, a key question is how health care reform programs will be financed. There are three main avenues being discussed on the campaign trail and in national and state legislatures.[1]

1. Rolling back high-income tax cuts. While a candidate, President Obama proposed restoring the high-income tax rates from 2000, yielding revenue of $65 billion per year.[2] However, it is unclear how fast the administration will move to enact such a change, in view of the faltering economy. Even if the tax rates are raised for high-income earners, tax revenue may not keep pace with rising health care costs, especially in a recession where government tax revenue can be expected to decrease.

2. Modifying the current tax exclusion for health benefits. The exclusion of employer health insurance premiums comprises the largest federal tax expenditure (see the chapter on employer-sponsored coverage for more). Capping or eliminating the tax exclusion would increase government tax revenue, but would also alter the financial incentive for employers to provide health insurance to their employees.

3. Play-or-pay model. Employers would be required to offer insurance to their employees or pay a tax to help pay for their employees to be covered elsewhere. This approach potentially strengthens and broadens the link between employers and health care, but could disproportionately affect small firms that are less likely to offer coverage. The play-or-pay model was part of the Massachusetts health reforms. Contrary to critics' fears, play-or-pay has not caused many employers to drop coverage in Massachusetts. [3]

The current recession will clearly affect where and how easily finances are obtained for health care changes. Most notably, decreasing incomes will lead to decreasing government tax revenue. As people lose their jobs or as businesses tighten their belts, there could be an increase in the number of uninsured or underinsured, thereby coupling decreased tax revenue with increased burden on public programs. Finally, economic strains on businesses could amplify some of the untoward economic effects of the financing proposals, such as the negative effect of taxation on investment and growth.

[1] For a more in-depth discussion of options to finance health reform, see Seshamani, Meena; Lambrew, Jeanne; Antos, Joseph (2008). "Financing the US Health System: Issues and Options for Change." Bipartisan Policy Center. (http://www.americanprogress.org/issues/2008/06/health_financing.html).
[2] Blumenthal, David; Cutler, David; Liebman, Jeffrey (2007). "Memorandum to Interested Parties: Obama Health Care Plan." The New York Times. (http://www.nytimes.com/packages/pdf/politics/finalcostsmemo.pdf).
[3] McDonough, John; Rosman, Brian; Mehreen; Butt, Mehreen (2008). "Massachusetts Health Reform Implementation: Major Profess And Future Challenges." Health Affairs Web Exclusive, June 3, p. w291. (www.healthaffairs.org).

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www.academyhealth.org

AFL- CIO
www.afl-cio.org

Alliance for Health Reform
www.allhealth.org

Alliance of Community Health Plans
www.achp.org

American Enterprise Insititute
www.aei.org

American Institutes for Research
www.air.org

American Medical Association
www.ama-assn.org

America's Health Insurance Plans
www.ahip.org

Blue Cross Blue Shield Association
www.bcbs.com

Boston University School of Management
http://management.bu.edu/index.html

Brookings Institution
www.brookings.edu

Cato Institute
www.cato.org

Center for Studying Health System Change
www.hschange.org

Center on an Aging Society, Georgetown University
http://ihcrp.georgetown.edu/agingsociety/

Center on Budget and Policy Priorities
www.cbpp.org

Centers for Medicare and Medicaid Services
www.cms.hhs.gov

Columbia University, Mailman School of Public Health
www.mailman.hs.columbia.edu/

Commonwealth Fund, The
www.commonwealthfund.org

Congressional Budget Office
www.cbo.gov

Consumers for Health Care Choice
www.chcchoices.org

Consumers Union
www.consumersunion.org

Council of Economic Advisors
http://www.whitehouse.gov/cea/

Employee Benefit Research Institute
www.ebri.org

ERISA Industry Committee
www.eric.org

Families USA
www.familiesusa.org

Federation of American Hospitals
www.fah.org

Galen Institute
www.galen.org

George Washington University Department of Health Policy
www.gwhealthpolicy.org

Government Accountability Office
www.gao.gov

Health Affairs
www.healthaffairs.org

Healthcare Leadership Council
www.hlc.org

High and Rising Health Care Costs: Demystifying U.S. Health Care Spending
http://www.rwjf.org/pr/product.jsp?id=35368

IMS Health
www.imshealth.com

Kaiser Family Foundation
www.kff.org

Kaiser Foundation Health Plan Inc.
www.kaiserpermanente.org

Lewin Group
www.lewin.com

Massachusetts General Hospital
www.mgh.harvard.edu

Medicare Payment Advisory Commission
www.medpac.gov

National Academy of Social Insurance
www.nasi.org

National Coalition on Health Care
www.nchc.org

New America Foundation
www.newamerica.net

Partners Healthcare
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Service Employees International Union
www.seiu.org

United Hospital Fund
www.uhfnyc.org

UnitedHealth Group
www.unitedhealthgroup.com

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